Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06800

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Pennsylvania — COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) (Last) Bittinger

4. DATE OF DEATH: (Month) July (Day) 16 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Dec. 24, 1902

9. AGE last birthday: 47 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland Near Jennings

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHarles Bittinger

14. MOTHER'S MAIDEN NAME: Sarah Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Cervix — Interval Between Onset and Death: 6 mos.

1717 Antecedent cause(s)

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Abdomen

(c) None

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 7, 1950, to July 16, 1950, that I last saw the deceased alive on July 15, 1950, and that death occurred at 7:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank Crowley M.D. Memorial Hospital Cumberland Md 7-16-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 7-16-50 — NAME OF CEMETERY OR CREMATORY: Hoover cemetary — LOCATION (City, town, or county) (State): near Jennings, Md.

DATE REC'D BY LOCAL REG.: July 16, 1950 — REGISTRAR'S SIGNATURE: Walter K. Canty M.D.

24. FUNERAL DIRECTOR — ADDRESS: Allen Winterberg Grantsville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

II

I

VS. A15

RECEIVED
JUL 25 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06801

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 76 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 407 Valley St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 407 Valley St.

3. NAME OF DECEASED (Type or Print): (First) Bertha (Middle) (Last) Blonskey

4. DATE OF DEATH: (Month) July (Day) 27 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write): Widowed

8. DATE OF BIRTH: Dec. 19, 1873

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Wm Bonckhouse

14. MOTHER'S MAIDEN NAME: Anna Walters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: John E Blonskey City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Embolus — Interval between onset and death: Very short time

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Chronic Thrombocystitis
(c) Prolapsus (of Uterus)

631 X
111 a
12 b 2
11 c
13 d 3

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 19 50, to July 27, 19 50, that I last saw the deceased alive on July 25 19 50, and that death occurred at 7 20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. L. Williams M.D. Cumberland 7/28/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: July 29, 1950

NAME OF CEMETERY OR CREMATORY: St. Lukes Cemetery

LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: July 29, 1950

REGISTRAR'S SIGNATURE: Walter L. Hantz M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc

ADDRESS: Cumb'd Md

RECEIVED
AUG 2 1950
BUREAU V. S

Within corporate limits

Dr. Schindler

07675

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 58 Greene St.

3. NAME OF DECEASED (Type or Print)	(First) Margaret	(Middle) L.	(Last) Bostetter	4. DATE OF DEATH	(Month) July (Day) 10, (Year) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: 12-26-1900	9. AGE last birthday: 49 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Millerdale, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: John L. Miller	14. MOTHER'S MAIDEN NAME: Flora Wolfe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs. Flora Miller Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Breast with metastases — 5-6 years

170 X Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to July 10, 1950, that I last saw the deceased alive on July 9, 1950, and that death occurred at 2:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B. M. Schindler MD, 41 Greene St, Cumberland, Md. July 11, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 7-12-1950	NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: July 12, 1950	REGISTRAR'S SIGNATURE: Winter R. Hantz M.D.	24. FUNERAL DIRECTOR: Charles L. George	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS A16

RECEIVED
JUL 18 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06802

CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville; LENGTH OF STAY (in this place) 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Ambrose (Last) Bower

4. DATE OF DEATH: (Month) July (Day) 24 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan. 1 1880

9. AGE last birthday: 70 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm owner

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bower

14. MOTHER'S MAIDEN NAME: Mary Coughenour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Curtis Bower

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 932 (b) Hypertension Heart Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH: 10 days and years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to July 24, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Allan G. Murray M.D. Cumberland July

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial

DATE THEREOF: July 27, 1950

NAME OF CEMETERY OR CREMATORY: Madley Cemetery

LOCATION (City, town, or county) (State): Hyndman, Pa. R.D. 1

DATE REC'D BY LOCAL REG.: July 26 1950

REGISTRAR'S SIGNATURE: J. Lloyd Wolfe

24. FUNERAL DIRECTOR ADDRESS: Harvey H. Zeigler, Hyndman, Pa.

OOOW

RECEIVED
AUG 9 1950
BUREAU

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06803

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 319 Emily St.,

3. NAME OF DECEASED (Type or Print) (First) Benjamin (Middle) Franklin (Last) Brelsford

4. DATE OF DEATH (Month) 7 (Day) 16 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S

8. DATE OF BIRTH 7/12/1888

9. AGE last birthday 62 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Freight House Employee

10b. KIND OF BUSINESS OR INDUSTRY WMRailway

11. BIRTHPLACE (State or foreign country) W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME William Brelsford

14. MOTHER'S MAIDEN NAME Sidney Richmond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs. Harvey Funk Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to July 16, 1950, that I last saw the deceased alive on July 15, 1950, and that death occurred at 6:15 p m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones (Degree or title) M.D. ADDRESS 110 S. Centre St DATE SIGNED July 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 7/19/50

NAME OF CEMETERY OR CREMATORY Abe Cemetery

LOCATION (City, town, or county) (State) Old Furnace, W. Va.

DATE REC'D BY LOCAL REG. July 19, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

26647

RECEIVED
JUL 25 1950
BUREAU V. S.

Within corporate limits JACOBSON

06804

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: MARYALND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, LENGTH OF STAY (in this place): 5-DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BARTON
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) DAVID	(Last) BROOKS	4. DATE OF DEATH	(Month) JULY	(Day) 14	(Year) 1950
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: NOV 7, 1871	9. AGE last birthday: 78 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~NONE~~ Miner-Retired	10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine	11. BIRTHPLACE (State or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: SOLOMON BROOKS	14. MOTHER'S MAIDEN NAME: MARY BROADWATER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Memorial Hosp.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Failure, Hypertension —

Antecedent cause(s)

444x 107

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Bronchopneumonia Rt. upper

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe Anemia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/8, 1950, to 7/14, 1950, that I last saw the deceased alive on 7/13, 1950, and that death occurred at 7:55 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) Camille Jacobson Lud — ADDRESS: 50 Pershing St. Cumberland — DATE SIGNED: 7/15/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: July 17, 1950	NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery	LOCATION (City, town, or county) (State): Moscow, Maryland
DATE REC'D BY LOCAL REG.: July 17, 1950	REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.	24. FUNERAL DIRECTOR: Ellsworth L. Boal	ADDRESS: Westernport, Md.

454V2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
JUL 25 1950
BUREAU V. S.

Within corporate limits

Dyer

MARYLAND STATE DEPARTMENT OF HEALTH

06805

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 T

1. PLACE OF DEATH: COUNTY: Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): MARYLAND 29 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 713 Virginia Ave	STREET ADDRESS (If rural, give location): 713 Virginia Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Andrew	Jackson	Brotemarkle	July	22	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Sept 22, 1867	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired farmer	General Farming	Cumberland Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Upton Brotemarkle	Margaret Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mrs Andrew J. Brotemarkle, Cmbd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac failure	3 days
592X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio	14 days
186a	(c) Chronic nephritis	14
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Fracture of 3, 4 + 5 dorsal vertebrae	4 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 22, 19 50, to July 22, 19 50, that I last saw the deceased alive on July 22, 19 50, and that death occurred at 7:45 P. m., from the causes and on the date stated above.

SIGNATURE: John A. Dyer (Degree or title) M.D. ADDRESS: 24 Va Ave. DATE SIGNED: 7-25-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 25, 1950	Rose Hill Mausoleum	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 25, 1950	Hunter A. Dantz, M.D.	John J. Hafer	Cumberland Md.

RECEIVED
AUG 2 1950
BUREAU V. S

What caused the fracture of the Dorsal Vertebrae? When, Where etc.?

How did injury occur? Accident?

Within corporate limits

Matthews

MARYLAND STATE DEPARTMENT OF HEALTH

06806

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 50 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 17 Cherry Place	STREET ADDRESS (If rural, give location): 17 Cherry Place

3. NAME OF DECEASED (Type or Print): (First) NANNIE (Middle) MAY FRANCES (Last) BULLETT				4. DATE OF DEATH: (Month) July (Day) 20, (Year) 1950		
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: May 1, 1873	9. AGE last birthday: 77 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own home	11. BIRTHPLACE (State or foreign country): Hampshire Co. W. Va.	12. CITIZEN OF WHAT COUNTRY?: USA			
13. FATHER'S NAME: UNKNOWN WELLS		14. MOTHER'S MAIDEN NAME: Sarah UNKNOWN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: Devonia Washington, Cumberland, Md.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypostasis

422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93e (b) Cerebral Apoplexy

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NO	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY: (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED: While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/8, 1949 to 7/20, 1950, that I last saw the deceased alive on 7/20, 1950 and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. B. Matthews III	M.D.	49 Green St Cumberland, Md.	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 23rd 1950	Camp Hill Cemetery	Paw Paw, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
July 22, 1950	Walter K. Lantz M.D.	William H. Kight, Cumberland, Md.

VS-A15

RECEIVED
JUL 25 1960
BUREAU V. S.

Within corporate limits

06807

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 25 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 407 Maryland Ave

3. NAME OF DECEASED (Type or Print)	(First) Michael	(Middle) Aloysuis	(Last) Byrnes	4. DATE OF DEATH	(Month) July (Day) 11 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Dec 26 1875	9. AGE last birthday: 74 yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Man	10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Springfield	11. BIRTHPLACE (State or foreign country): Midland, Maryland	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: Patrick Byrnes	14. MOTHER'S MAIDEN NAME: Diana Byrnes				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 217-10-6781	17. INFORMANT AND ADDRESS: Joseph Byrnes, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) acute coronary occlusion	1 day
Antecedent cause(s) 420.0	(b) arteriosclerotic heart disease	1 year
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(c) —	—

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1-, 1949, to 7-11-, 1950, that I last saw the deceased alive on 7-11-, 1950, and that death occurred at 9 45 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L. Wrings	MD	57 Greene St.	7-12-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: July 14 1950	NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: July 14, 1950	REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight,	ADDRESS: Cumberland, Md.

49635

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JUL 18 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06808

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 28 Years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 605 Fairview Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 605 Fairview Ave

3. NAME OF DECEASED (Type or Print): (First) Michael (Middle) Hobart (Last) Calhoun

4. DATE OF DEATH: (Month) July (Day) 26 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 29 1900

9. AGE last birthday: 50 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Community Baking Company

11. BIRTHPLACE (State or foreign country): Clarksville, W. Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Aaron Calhoun

14. MOTHER'S MAIDEN NAME: Jessie Engle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-5166

17. INFORMANT: Mrs Jessie Calhoun, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	3 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE. (Degree or title) ADDRESS DATE SIGNED

Benedict Kitarelic M. D. Rt 2 Cumberland Md. 7/26/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF July 29/50; NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery; LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. July 28, 1950; REGISTRAR'S SIGNATURE Walter K. Franz, M.D.

24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

26661

When corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 2 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

06809

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) 330 N. Mechanic St.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	George	Love	Campbell		7	7	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Married	11/18/67	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
janitor	Presbyterian Church	Newburg W. Va.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Campbell	Elizabeth Love

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No	None	son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	12 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	2 yrs
	(c)	

420.1 94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 26, 1950, to July 7, 1950, that I last saw the deceased alive on July 7, 1950, and that death occurred at 10:50 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	July 10, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 10, 1950	Iron Memorial Cemt	Near Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 10, 1950	Walter R. Hantz, M.D.	William A. Light	Cumberland, Md.

VS. A15

740 94

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BUREAU V. S.

Dr. T. A. Robinson

Within corporate limits

06810

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 44 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: West Virginia — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeley
STREET ADDRESS (If rural, give location): 32 Carpenter Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) Cassell

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1-6-50

9. AGE last birthday: yrs. — If under 1 year: Months 5, Days 26 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Not given

14. MOTHER'S MAIDEN NAME: Evelyn Cassell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hydrocephalus

751X Antecedent cause(s)

157a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) meningocele

(c)

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12, 19 50, to 7/2, 19 50, that I last saw the deceased alive on 7/2, 19 50, and that death occurred at 11:50 a.m., from the causes and on the date stated above.

SIGNATURE: Thomas Robinson — (Degree or title): M. D. — ADDRESS: 19 A. Liberty st Cumberland — DATE SIGNED: 7/3/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: July 3, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: July 3, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz M.D. — 24. FUNERAL DIRECTOR: Louis Stein, INC. — ADDRESS: Cumberland, Maryland

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06811

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 206 Smoot St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 206 Smoot Street

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) HENRY (Last) CLAYTON

4. DATE OF DEATH: (Month) July (Day) 6 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan 14, 1868

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Box maker retired

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jonothon M. Clayton

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ✓ (If year, give war or dates of service): ✓

16. SOCIAL SECURITY No.: 212-12-8350

17. INFORMANT: John Clayton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592x Immediate cause (a) Arteriosclerosis — Interval Between Onset and Death: 1 yr

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Myocarditis — 1 yr

(c) Chronic Nephritis — 1 yr

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Uremia — 2 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1950, to July 6, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 9:10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thomas Reese, M.D. Westernport Md. July 7, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: July 9 50

NAME OF CEMETERY OR CREMATORY: Philos Cemetery

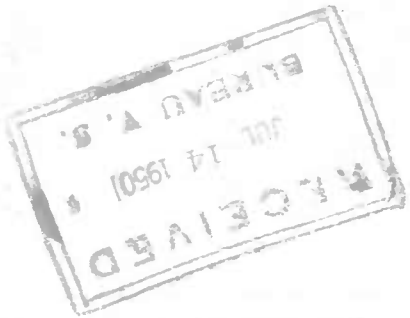
LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG. July 8 50

REGISTRAR'S SIGNATURE: A. Bayne-Baker M.D.

21. FUNERAL DIRECTOR ADDRESS: E. S. Boal, Westernport, Md.

4961/2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Within corporate limits

06812

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, — LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: West Virginia — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeley, Rural
STREET ADDRESS (If rural, give location): R. D. #1 St. Rt. # 28

3. NAME OF DECEASED (Type or Print): (First) ARCHIE (Middle) FRANCIS (Last) DAVIS

4. DATE OF DEATH: (Month) July (Day) 30, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 16, 1888

9. AGE last birthday: 62 yrs. — If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed engineer

10b. KIND OF BUSINESS OR INDUSTRY: Allegany Ballis

11. BIRTHPLACE (State or foreign country): Indianapolis, Indiana

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Frank Davis

14. MOTHER'S MAIDEN NAME: Lina Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: 213-05-8917

17. INFORMANT AND ADDRESS: Self----- Previous arrangements

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Dilatation	2 days
Antecedent cause(s)	(b) Myocarditis	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Bronchial Asthma	?

241X
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1950, to July 30, 1950, that I last saw the deceased alive on July 30, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Clay R. Durrett - Md - ADDRESS: Cumberland - DATE SIGNED: 8/1/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 8/2/50 | NAME OF CEMETERY OR CREMATORY: Blumont Cem. | LOCATION (City, town, or county) (State): Grafton, W. Va.

DATE REC'D BY LOCAL REG.: Aug. 2, 1950 | REGISTRAR'S SIGNATURE: Walter K. Franz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: Charles L. George, Cumberland, Md.

VS. A15

35699

RECEIVED
AUG 7 1950
BUREAU V. S

06813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 707 Hill Top Drive

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 707 Hill Top Drive

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) McClimate (Last) Feremer

4. DATE OF DEATH: (Month) July (Day) 31 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec 12 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? Brit.

13. FATHER'S NAME: Robert McKean

14. MOTHER'S MAIDEN NAME: Jennet McFadgent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Myrtle Amstat, 707 Hill Top Dr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Coronary Thrombosis — Interval Between Onset and Death: Short time

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Coronary Arteriosclerosis

420.1
94a

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1950 to July 31, 1950, that I last saw the deceased alive on July 25, 1950, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. K. Williams M.D. ADDRESS: Cumberland DATE SIGNED: 8-2-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 3, 1950	Hillcrest Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 3, 1950	Walter R. Lantz M.D.	John J. Hafer	Cumberland Md.

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BUREAU

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06814

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 705 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Paul (Last) Dorsey

4. DATE OF DEATH: (Month) July (Day) 7 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Write one): Single

8. DATE OF BIRTH: July 6 1883

9. AGE (last birthday) 67 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Inspector & Foreman

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Retired

11. BIRTHPLACE (State or foreign country): Keyser W. Va

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas Dorsey

14. MOTHER'S MAIDEN NAME: Catherine Cruise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Wm Dorsey, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) generalized arteriosclerosis	years
	(c)	

420.1
94 a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to July 7, 1950, that I last saw the deceased alive on July 7, 1950, and that death occurred at 11 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. M. Schindler M.D. ADDRESS 41 Greene St, Cumberland Md DATE SIGNED July 9/1950

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE THEREOF: 7/11/50

NAME OF CEMETERY OR CREMATORY: St Peter & Paul's Cem

LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: July 10, 1950

REGISTRAR'S SIGNATURE: Walter L. Dantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein, Inc ADDRESS: Cumberland

31847

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JUL 19 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

06815

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 17 N. Grant

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Thomas (Last) Edmunds

4. DATE OF DEATH: (Month) July (Day) 5 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Jan. 10-1880

9. AGE last birthday: 70 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): South Wales

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Thomas

14. MOTHER'S MAIDEN NAME: Jane Perkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mrs. Nancy Accoglio, Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Sudden.
420.1 Antecedent cause(s)		several
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1947, to July 5, 1950, that I last saw the deceased alive on June 20, 1950, and that death occurred at 3:30 A m., from the causes and on the date stated above.

SIGNATURE: Wm Lane MD (Degree or title) ADDRESS: Frostburg Md DATE SIGNED: 7-5-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: July 8, 1950
NAME OF CEMETERY OR CREMATORY: Frostburg Memo. Park
LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG.: 7-7-50
REGISTRAR'S SIGNATURE: Mrs. J. M. Price (acting)

24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Frostburg, Md.

VS. A15

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JUL 10 1950
BUREAU V. S.

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06816

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ACCIDENT
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) Marie (Last) FIKE

4. DATE OF DEATH: (Month) JULY (Day) 3 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: MARCH 2, 1910

9. AGE last birthday: 40 yrs. — If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: MR. ALEX GEORGE

14. MOTHER'S MAIDEN NAME: KATIE BITZLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MR. FORD FIKE, HUSBAND, ACCIDENT, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Nephritis (Uremia)	2 wks.
Antecedent cause(s) 490X	(b) Lobar Pneumonia (left lower)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 108	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 6-26-, 1950 to 7-3-, 1950, that I last saw the deceased alive on 7-2-50, 19..., and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE: W. F. Williams — (Degree or title): M.D. — ADDRESS: Cumberland — DATE SIGNED: 7-3-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: July 5 1950 — NAME OF CEMETERY OR CREMATORY: Nova Lutheran Cem. — LOCATION (City, town, or county) (State): Accident, Maryland

DATE REC'D BY LOCAL REG.: July 3, 1950 — REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR: Emroy Bolden — ADDRESS: Oakland

Md

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JUL 11 1950
BUREAU V. B.

06817

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. P. R. Wilson

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING - PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport | LENGTH OF STAY (in this place) 53 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 312 Spruce Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 312 Spruce Street

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) C R (Last) FOSTER

4. DATE OF DEATH: (Month) (Day) (Year) July 16, 1950 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 21, 1872

9. AGE last birthday: 78 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Screen Operator Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Foster

14. MOTHER'S MAIDEN NAME: Susan Kooken

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service) - - -

16. SOCIAL SECURITY NO.: 217-01-9790

17. INFORMANT: Glenn Foster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral arteriosclerosis	3 years
334X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 97	(b) Generalized arteriosclerosis	15 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16, 1950, to 7-16, 1950, that I last saw the deceased alive on 7-16, 1950, and that death occurred at 6:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James H Wolverton M.D. | ADDRESS Piedmont W.Va | DATE SIGNED 7-19-50

23. BURIAL, CREMATION REMOVAL, (Specify) Burial | DATE THEREOF July 19, 50 | NAME OF CEMETERY OR CREMATORY Philos Cemetery | LOCATION (City, town, or county) (State) Westernport, Md.

DATE REC'D BY LOCAL REG. July 19/50 | REGISTRAR'S SIGNATURE A Bayne Baer M.D.

24. FUNERAL DIRECTOR E. S. Boal | ADDRESS Westernport, Maryland

49611

VS. A15

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1950
BUREAU V.S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

06818

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-415A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland Rural — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hinkle Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 725 Pear St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Andrew (Last) Frost

4. DATE OF DEATH: (Month) July (Day) 31 (Year) 1950

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write): Married | 8. DATE OF BIRTH: March 18 1877 | 9. AGE last birthday: 73 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor Retired
10b. KIND OF BUSINESS OR INDUSTRY: Railway
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Frost
14. MOTHER'S MAIDEN NAME: Anna Gelhause

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-05-9484
17. INFORMANT: Sylvia A. Frost (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	30 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	
	(c)	

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II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benedict Skitarelic	M. D.	Rt #2 Cumberland Md.	Aug 1 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug 3 50	St Peter & Pauls Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 2, 1950	Walter L. Dantz, M.D.	Louis Stein Inc	"

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AUG 4 1950
BUREAU V. S

06819

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport, LENGTH OF STAY (in this place): 36 years.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport,
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location): 434 Hammond Street,

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Alfonso Garritano.			4. DATE OF DEATH (Month) (Day) (Year): July 2, 1950	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Nov. 19, 1874.	9. AGE last birthday: 75 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber.	10b. KIND OF BUSINESS OR INDUSTRY: Self Employed.	11. BIRTHPLACE (State or foreign country): Cosenza, Celico Province, Italy.	12. CITIZEN OF WHAT COUNTRY? C. P.	
13. FATHER'S NAME: Don't Know		14. MOTHER'S MAIDEN NAME: Don'T Know		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes. (If year, give war or dates of service): W.W.#1.	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Mrs. Alfonso Garritano. Westernport, Md		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Embolus	1 Day
Antecedent cause(s)	Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic	4 Years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	4 Years

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19a. DATE OF OPERATION: None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): None	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 10, 1946, to July 2, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 3:05 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Paul R Wilson MD.	Piedmont, W. Va.	July 4, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/5/50	Hill Crest Cemetery	Cumberland, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 5/50	A. Gazenbaker MD	W. Daniel Fullock Jr	Piedmont, W.Va.

70089

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
JUL 7 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

06820

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (In this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. #3 Mt. Pleasant Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) R.D. #3 Mt. Pleasant Rd.

3. NAME OF DECEASED (Type or Print): (First) EMMA (Middle) ELWOOD (Last) HARPER

4. DATE OF DEATH: (Month) July (Day) 15, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 7/30/1875

9. AGE last birthday: 74 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Does None Domestic

11. BIRTHPLACE (State or foreign country): Moorefield, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Evans

14. MOTHER'S MAIDEN NAME: Mary Jane Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John S. Harper R. D. #3 Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	?
	(c)	

420.1
9da

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arthritis deformans also hemiplegia, left side 6 yrs.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H. V. Deming M.D. H. V. Deming M.D. | ADDRESS: Cumberland, Md. | DATE SIGNED: 7/15/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 7/17/50 | NAME OF CEMETERY OR CREMATORY: Hillcrest Cem. | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. July 17, 1950 | REGISTRAR'S SIGNATURE: Walter L. Hantz M.D. | 24. FUNERAL DIRECTOR: Charles L. George | ADDRESS: Cumberland, Md.

VS. A15A

RECEIVED
JUL 25 1960
BUREAU U.S.

Within corporate limits

06821

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 104 Virginia Avenue

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Anna Hebb
4. DATE OF DEATH (Month) (Day) (Year): 7 17 1950

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Aug. 19 1877
9. AGE last birthday: 72 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Washington County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Chaney
14. MOTHER'S MAIDEN NAME: Louisa Wiley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Lana Wolfe 104 Virginia Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Adenocarcinoma Uteri — 5 yrs

174X Antecedent cause(s)

48b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1950, to July 17, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 12 33 p.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones M.D. (Degree or title) — ADDRESS: 110 S. Centre St. — DATE SIGNED: July 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 7/20/50 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cem. — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: July 19, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1980
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06822

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 123 West Oldtown Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 123 West Oldtown Road

3. NAME OF DECEASED (Type or Print): (First) Norine (Middle) June (Last) Heier

4. DATE OF DEATH: (Month) July (Day) 22 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: June 19, 1913

9. AGE last birthday: 37 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & waitress

10b. KIND OF BUSINESS OR INDUSTRY: Martz Cafe

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles Wassen

14. MOTHER'S MAIDEN NAME: Elnora (Kendell)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 215-20-5746

17. INFORMANT AND ADDRESS: Charles Wassen Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171 X Immediate cause (a) Carcinoma of cervix — Interval between onset and death: 1 year

Antecedent cause(s)

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 18 49, to Present, 19....., that I last saw the deceased alive on July 20, 1950, and that death occurred at 6:20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank T. Conley M.D. ADDRESS Memorial Hospital Cumberland Md. DATE SIGNED 7-22-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 7/25/50 — NAME OF CEMETERY OR CREMATORY Rose Hill — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. July 25 1950 — REGISTRAR'S SIGNATURE Walter K. Hantz, M.D.

24. FUNERAL DIRECTOR H. Wayne George — ADDRESS Cumberland, Md.

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AUG 2 1950
BUREAU V. S

Within corporate limits

06823

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 50 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 331 Frederick St	STREET ADDRESS (If rural, give location): 331 Frederick St

3. NAME OF DECEASED (Type or Print) (First) Bertha (Middle) (Last) Hollingsworth			4. DATE OF DEATH (Month) July (Day) 7 (Year) 1950		
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Feby 15 1879	9. AGE last birthday: 71 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: House Keeping	11. BIRTHPLACE (State or foreign country): Moorefield, W. Va.	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: John Hollingsworth		14. MOTHER'S MAIDEN NAME: Rachel Ann Willis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs Edith Taylor, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Sarcoma Right Dr Femur — 1 1/2 yrs

196X Antecedent cause(s)

55b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

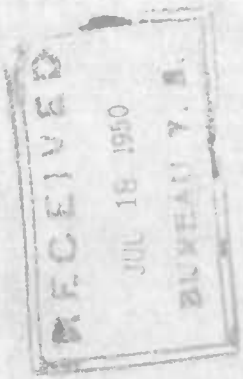
22. I hereby certify that I attended the deceased from July, 1946, to July, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 1-45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B. M. Schendler	M.D.	41 Everett Cumberland, Md	July 7 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: July 9 1950	NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: July 9, 1950	REGISTRAR'S SIGNATURE: Walter R. Frantz M.D.	24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.	ADDRESS

52086

Dr Schindler



Within corporate limits

HOTT BROADRUP

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06824

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (in this place) 2 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 115 OFFUTT STREET

3. NAME OF DECEASED (Type or Print)	(First) BABY	(Middle) BOY	(Last) HOTT	4. DATE OF DEATH	(Month) July (Day) 17 (Year) 1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 16, 1950	9. AGE last birthday yrs.	If under 1 year Months. 1 Days 1 day; If under 24 hrs. Hours Min. 37
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray ~~HOTT~~ HOTT			14. MOTHER'S MAIDEN NAME MARY LONG		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	(If year, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Injury at birth, instrument delivery	One day.
760.0 Antecedent cause(s)	(b) with intracranial hemorrhage	
160a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) associated with difficult labor	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. and malposition of fetus.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 16, 1950, to July 17, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E. E. T. Broadrup	M.D.	Cumberland Maryland	July 18. 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/19/1950	Abe Cemetery	RFD 1, Ridgeley, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 19, 1950	Winter K. Hantz M.D.	William H. Kight, Cumberland, Md.	

2-0-7-16-0-17-1-40-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
JUL 25 1960
BUREAU V. S.

Evidence for addition in #18 shown on:

FILM No. G 128 OCT 10 1950

Dr. Wolferman

06825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Centennial St.	STREET ADDRESS (If rural, give location): Centennial Street

3. NAME OF DECEASED (Type or Print)	(First) ROBERT	(Middle) ANDREW	(Last) HUSTON	4. DATE OF DEATH	(Month) July (Day) 7 (Year) 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: July 2-1879	9. AGE last birthday: 71 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired mine operator	10b. KIND OF BUSINESS OR INDUSTRY: coal mines	11. BIRTHPLACE (State or foreign country): Frostburg, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Joseph Huston	14. MOTHER'S MAIDEN NAME: Anna Wise				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 214-91-0326	17. INFORMANT AND ADDRESS: Mrs. Robt. Huston, Frostburg, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) respiratory failure	2 weeks
795.0 Antecedent cause(s)	Cardiac failure of unknown cause	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) chest disease most likely pulmon tuberc (diagnosis not established because of lack of cooperation)	many years
200b	(c) no proof available - (10/9/50 akc)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to July 7, 1950, that I last saw the deceased alive on June 24, 1950, and that death occurred at 6 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Adolf Wolferman M.D. — ADDRESS: Frostburg — DATE SIGNED: 7-8-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: July 10-50	NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 7-10-50	REGISTRAR'S SIGNATURE: Mrs. J. M. Price	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

454V2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

RECEIVED
JUL 12 1950
BUREAU V. S.

Outside of City Limits

06826

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural) Cumberland
LENGTH OF STAY (In this place): 75 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Johnson Road, R.F.D.#2

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland
STREET ADDRESS (If rural give location): Johnson Road, R.F.D.#2

3. NAME OF DECEASED (Type or Print): Charles (First) Alva (Middle) Johnson (Last)

4. DATE OF DEATH: July (Month) 2 (Day) 1950 (Year)

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Jan. 9-1875

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Dairy farm

11. BIRTHPLACE (State or foreign country): ~~Maryland~~ Allegany Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John L. Johnson

14. MOTHER'S MAIDEN NAME: Almira Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Jasper C. Johnson (brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute cardiac failure due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular-renal disease.	over a yr
442 X 131a	(c) arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming MD Cumberland, Md. July 3-1950

23. BURIAL, CREMATION REMOVAL, (Specify): Burial | **DATE THEREOF**: 7/5/50 | **NAME OF CEMETERY OR CREMATORY**: Old Christie Cemetery | **LOCATION (City, town, or county)**: Allegany Co. | (State): Md.

DATE REC'D BY LOCAL REG.: July 5, 1950 | **REGISTRAR'S SIGNATURE**: Merle K. Hartz, M.D. | **24. FUNERAL DIRECTOR** | **ADDRESS**: John J. Hofer, Cumberland, Md.

VS. A15A

RECEIVED
JUL 11 1950
BUREAU T. S

Within corporate limits

06827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH COUNTY: Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 675 Shriver Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 675 Shriver Ave.

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) M. (Last) Kastner
4. DATE OF DEATH (Month) July (Day) 4 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Feb. 25, 1888
9. AGE last birthday: 62 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Seifers
14. MOTHER'S MAIDEN NAME: Katherine Soethe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Anthony P Kastner City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	1 day
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive heart disease	2 years
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from on 7-4, 1950, to —, 19....., that I last saw the deceased alive on 7-4-, 1950, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE: Ralph W. Ballin, M.D. (Degree or title) ADDRESS: 62 Greene St. Cumberland Md DATE SIGNED: 7-5-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: July 7-50
NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem
LOCATION (City, town, or county): Cumberland (State): Maryland
DATE REC'D BY LOCAL REG.: July 6, 1950
REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc ADDRESS: Cumberland

MARGIN RESERVED FOR BINDING

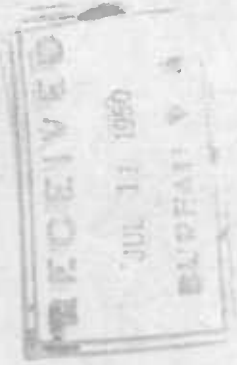
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

Ballin. 5798

Ballin
62 Broad St



Evidence for change of age shown on:

06828

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. P. R. Wilson

CERTIFICATE OF DEATH

FILM No. G 127 JUL 31 1950

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke; LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Cromwell Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke

STREET ADDRESS (If rural, give location) Cromwell Street

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) EDWARD (Last) KELLER

4. DATE OF DEATH: (Month) July (Day) 11, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 3, 1888

9. AGE last birthday: 67 66 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob R. Keller

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-07-2282

17. INFORMANT: Mrs. Robert E. Keller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic, — Interval Between Onset and Death: 1 Year

241x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Bronchitis (Asthma) — 1 Year

93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 2, 1950, to July 11, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 10:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul R Wilson M.D. Piedmont W. Va. July 13, 1956

23. BURIAL, CREMATION, REMOVAL (Specify): BURIED — DATE THEREOF: July 14, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Hagerstown, Maryland

DATE REC'D BY LOCAL REG.: July 13 56 — REGISTRAR'S SIGNATURE: A Bazinbaker M.D.

24. FUNERAL DIRECTOR: E. S. Boal — ADDRESS: Westernport, Maryland

32611

VS. A15

RECEIVED
JUL 15 1950
BUREAU V. R.

Within corporate limits

06829

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 16 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa.; COUNTY: Sommersett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (rural) R.F.D #1 Hyndman
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ira	E.	Kennell	July	4	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	single	May 17-1919	31 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	farming Own farm	Wellersburg Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clarence Kennell	Effie Rizer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes W.W.#2	None	Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

902.1 **Immediate cause** (a) Maceration of the spinal cord due to Compressed — about 18 hrs

186a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture of the 5th. cervical vertebrae.

(c) Fell 12 ft. from a load of hay.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: in barn.	(CITY OR TOWN): near Hyndman	(COUNTY): Sommerset	(STATE): Pa.
TIME OF INJURY (Month) (Day) (Year) (Hour): about July 3/50 P. m.	INJURY OCCURRED While at work ☒ Not while at work ☐	HOW DID INJURY OCCUR? Fell from a load of hay, about 12ft. hittingon head & back		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland, Md.	July 4-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 7, 1950	Cooks Cemetery	Near Wellersburg, Penna

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 5, 1950	Walter K. Frantz, M.D.	Harvey A. Zigler	Hyndman, Penna.

OOVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 11 1950
BUREAU OF

06830

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. R. W. Reeves

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 64 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 316 Johnson St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 316 Johnson Street

3. NAME OF DECEASED (Type or Print): (First) SARAH (Middle) (Last) KLINE
4. DATE OF DEATH: (Month) July (Day) 26 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Dec 19, 1868
9. AGE last birthday: 81 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Frostburg Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jerry Saville
14. MOTHER'S MAIDEN NAME: Ellen Loar
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. William H. Wilson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Cardio Vascular, Renal

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 1949, to 7/26, 1950, that I last saw the deceased alive on 7/24, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

R W Reeves M.D. Westernport Md 7/27/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 29, 1950 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG. July 29/50 — REGISTRAR'S SIGNATURE: G Bazenbaker M.D.

24. FUNERAL DIRECTOR: E. S. Boal — ADDRESS: Westernport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 1 1950
BUREAU V. S

06831

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonacony
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Lonacony
(If outside city or town limits, write RURAL and give nearest town)

Street No. –
(If rural, give LOCATION)

2.(a) If veteran, name war –

3.(a) FULL NAME Edith Sarah Kroll

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John H. Kroll

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 21st 1891

8. AGE:

Years	Months	Days	If less than one day
58	6	17	..... hrs. ..... min.

9. Birthplace Frostburg, Md
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Own Home

FATHER
12. Name Johnson C DeVore
13. Birthplace Frostburg, Md

MOTHER
14. Maiden name Aurellia Crowe
15. Birthplace Avilton, Md

16. Informant Mrs. Jesse Porter
Address Lonacony, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11, 1950 (month) (day) (year)

Cemetery or crematory Old Coney Cemetery

Location Lonacony, Md

18. Funeral director M. Eichhorn
Address Lonaconing, Md

19. July 11 1950 (Date rec'd by registrar) Jeanette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1950, at 7.50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1947 to 1950

and that I last saw her alive on 7/8/50 1950

Immediate cause of death

DURATION

Due to Cardio Vascular Dis 3 yr.

Due to Diabetes amputation left 4th toe.

Other conditions 260X 61
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Currier M.D.
M. D. or other

Address Keyser W. Va. Date signed 7/8/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

I

Within corporate limits

Dr. Mitchell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06832

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): ; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 505 Valley St.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 505 Valley St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Mitchell	Lederer	July	3,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Aug. 20, 1892	57 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator in Millroom	Tire Factory	So. Branch, W. Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Herman Lederer	Laura Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No	214-05-5156	Mrs. Chloe Lederer Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
154x Immediate cause	(a) Carcinoma of rectum with metastasis to the liver-	15 months
Antecedent cause(s)		
462 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan. 24, 1950, to July 3, 1950, that I last saw the deceased alive on July 3, 1950 and that death occurred at 10:00P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. Murman M.D. 115 S. Centre St., Cumb. Md. 7/6/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-6-1950	Zion Memorial	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 6, 1950	Chester R. Hartz M.D.	Charles L. George	Cumberland, Md.

49635

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 11 1890
BUREAU T. S.

Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06833

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.	STREET ADDRESS (If rural, give location) 234 N. Mechanic St.,

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) Reverdy (Last) LINDNER

4. DATE OF DEATH: (Month) July (Day) 27, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 4, 1885

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Manager

10b. KIND OF BUSINESS OR INDUSTRY: Tire recapping

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George M. Lindner

14. MOTHER'S MAIDEN NAME: Florence Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Rosemary Lindner 234 N. Mechanic St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443 x Immediate cause	(a) Intra-ventricular Hemorrhage disease	2 days
93d Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive cardiovascular	10 yrs
	(c) Essential Hypertension	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: no

19b. MAJOR FINDINGS OF OPERATION: no

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no (CITY OR TOWN) no (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) no m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from ....., 1948, to July 27, 1950, that I last saw the deceased alive on July 26, 1950, and that death occurred at 2 35 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Aurelle G. Cuersmanhus 59 Greene St Cumberland 7/27/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 7/29/50

NAME OF CEMETERY OR CREMATORY: S. S. Peter & Paul

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: July 28 1950

REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.

24. FUNERAL DIRECTOR ADDRESS: H. Wayne George Cumberland, Md.

15635

RECEIVED
AUG 2 1950
BUREAU V. S

06834

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
LENGTH OF STAY (in this place) 68
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
STREET ADDRESS (If rural, give location) Main St.

3. NAME OF DECEASED (Type or Print) (First) Agnes (Middle) Noonan (Last) Logsdon
4. DATE OF DEATH (Month) July (Day) 3 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED Married
8. DATE OF BIRTH Dec 10 1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Mt Savage Md
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME James Noonan
14. MOTHER'S MAIDEN NAME Ellen Dunnigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Everette B Logsdon, Mt Savage

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
331x	Immediate cause	(a) CEREBRAL HEMORRHAGE	3 days.
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) VASCULAR HYPERTENSION	10 years.
		(c) ARTERIO SCLEROSIS	10 years.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1945, to 7-3, 1950, that I last saw the deceased alive on 7-3, 1950, and that death occurred at 5 30 P.M., from the causes and on the date stated above.

SIGNATURE William E. Moseley (Degree or title) ADDRESS Mt Savage, Md. DATE SIGNED July 4-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 7, 50
NAME OF CEMETERY OR CREMATORY St Patricks Cem.
LOCATION (City, town, or county) Mt Savage (State) Md.

DATE REC'D BY LOCAL REG. July 6 - 1950
REGISTRAR'S SIGNATURE Veronica McDermott
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 10 1950
BUREAU V. S.

Within corporate limits

06835

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 317 Independence Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 317 Independence Street

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) CHARLES (Last) MACKERT

4. DATE OF DEATH: (Month) July (Day) 30, (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Single	Dec. 7, 1880	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bar Tender	Fraternal Club	Cumberland, Md.	USA

13. FATHER'S NAME: August Mackert

14. MOTHER'S MAIDEN NAME: Catherine Luthmun

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214 05 6481

17. INFORMANT: W. N. Mackert Cumberland, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	30 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	10-15 yrs.
	(c)	

420.1
940

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Benedict Skitarelic M. D. Rt #2 Cumberland, Md 7/31/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 2, 1950	St. Peter & Pauls Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 1, 1950	Walter K. Frantz, M.D.	William H. Kight, Cumberland, Md.	

7/0 71

VS. A15A

RECEIVED
AUG 7 1950
BUREAU Y. S

06836

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
LENGTH OF STAY (in this place) 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rail Road St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) Rail Road St

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Francis (Last) Malloy

4. DATE OF DEATH (Month) July (Day) 6 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5-26-1882
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME George F. Malloy
14. MOTHER'S MAIDEN NAME Mary Hull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 214-01-0070
17. INFORMANT AND ADDRESS Mrs. Geo F. Malloy Mt. Savage Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) Arteriosclerotic Heart Disease

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary occlusion — One hour

(c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5, 1950, to July 6, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 1.45 A m., from the causes and on the date stated above.

SIGNATURE James P. Hallinan MD (Degree or title) ADDRESS 200 Decatur St. Cumberland Md. DATE SIGNED 7/7/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7-8-1950
NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.
LOCATION (City, town, or county) (State) Mt Savage, Md

DATE REC'D BY LOCAL REG. July 7 1950
REGISTRAR'S SIGNATURE Veronica McDermott
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md

30447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 10 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06837

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone
STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print) (First) Cinda (Middle) Kay (Last) May
4. DATE OF DEATH (Month) July (Day) 18 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH October 13, 1949
9. AGE last birthday yrs. If under 1 year Months 9 Days 5 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Franklin L. May
14. MOTHER'S MAIDEN NAME Catherine V. Delawder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Franklin L. May, Rt. 2, Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchopneumonia

491X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) malnutrition

107 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. malnutrition

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1950, to July 18, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 9 40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth Bringo ADDRESS 55 Greene St. DATE SIGNED 7/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 20, 1950
NAME OF CEMETERY OR CREMATORY Glendale Brethren Cemetery
LOCATION (City, town, or county) Allegany Co. (State) Md.

DATE REC'D BY LOCAL REG. July 20, 1950
REGISTRAR'S SIGNATURE Wrates R. Fantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

2-0-0-13-9-25-5-40-V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

E. Bridges

RECEIVED
JUL 25 1960
BUREAU T. S.

06838

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cresaptown
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 5 Cumberland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cresaptown
STREET ADDRESS (If rural give location) Rt. 5, Cumberland

3. NAME OF DECEASED (Type or Print) (First) John (Middle) David (Last) McKenzie
4. DATE OF DEATH (Month) July (Day) 21 (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Dec. 17, 1941
9. AGE last birthday 8 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Cumberland, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Clarence McKenzie
14. MOTHER'S MAIDEN NAME Ora Lease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Clarence McKenzie, Rt. 5, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intracranial hemorrhage	3 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Rupture of Congenital aneurysm of Circle of Willis	" "

7546
157f

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Benedict Skitarelic (Degree or title) M.D. ADDRESS Route #2 Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/24/50
NAME OF CEMETERY OR CREMATORY Lease Cemetery
LOCATION (City, town, or county) Allegany Co (State) Md

DATE REC'D BY LOCAL REG. 7/22/50
REGISTRAR'S SIGNATURE M A Vernon
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 25 1980
BUREAU V. B.

Within corporate limits

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06839

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 20 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MIDLAND
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) LEO (Middle) W. (Last) McKENZIE

4. DATE OF DEATH (Month) JULY (Day) 18 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH 4/27/1865
9. AGE last birthday 85 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY Own farm
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME ISIDOR McKENZIE
14. MOTHER'S MAIDEN NAME Henrietta Gartitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma lung, right ?

163x Antecedent cause(s)

47d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 July 1950, to 18 July, 1950, that I last saw the deceased alive on 18 July, 1950 and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Alfred Van Ormer, M.D. ADDRESS Cumberland, Md. DATE SIGNED 20 July 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE July 21, 1950
NAME OF CEMETERY OR CREMATORY Belvedere Cemetery
LOCATION (City, town, or county) (State) Midland, Maryland.

DATE REC'D BY LOCAL REG. July 21, 1950
REGISTRAR'S SIGNATURE Charles L. Frantz M.D.
24. FUNERAL DIRECTOR M. Eichhorn, Lonaaconing, Md. ADDRESS

OOOVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1950
BUREAU V. R

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06840

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 703 Oldtown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 703 Oldtown Rd.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	LAURA	JANETTE	MILLER		July	31,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	May 17, 1865	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Bedford Valley, Penna.	U. S.

13. FATHER'S NAME: Henry Miller

14. MOTHER'S MAIDEN NAME: Deborah Ruby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	Mrs. Osa Brotemarkle Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive Arterio-

420.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Sclerotic heart disease

(c) Chronic Myocardial Degeneration

INTERVAL BETWEEN ONSET AND DEATH: Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or conditinn causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Nnt While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 1, 1949, to May 31, 1950, that I last saw the deceased alive on July 31, 1950, and that death occurred at 7:05 P. m., from the causes and on the date stated above.

SIGNATURE: W. L. Williams — (Degree or title) MD — ADDRESS: Cumberland — DATE SIGNED: 8-2-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 3, 1950	Hillcrest	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
Aug. 3, 1950	Winter L. Canty, M. D.	H. Wayne George Cumb. Md.

5-20-86

RECEIVED
AUG 7 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06841

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) THEOPHILUS (Middle) (Last) MORGAN

4. DATE OF DEATH: (Month) July (Day) 1 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan 10 1877

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter retired

10b. KIND OF BUSINESS OR INDUSTRY: Brick Yard

11. BIRTHPLACE (State or foreign country): Echart, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theopilus Morgan

14. MOTHER'S MAIDEN NAME: Annie Byrd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-0068

17. INFORMANT: Mrs. Theopilus Morgan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592x — Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 2 weeks -

260x — Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 61 — (b) Chronic Interstitial Nephritis — Interval Between Onset and Death: unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — Interval Between Onset and Death: Several years.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED White at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-18, 1950, to 7-1, 1950, that I last saw the deceased alive on 7-1, 1950, and that death occurred at 10:45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) William E. Mosley — ADDRESS Mt Savage Md. — DATE SIGNED 7-2-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 5, 50 — NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: July 3 - 50 — REGISTRAR'S SIGNATURE: Vernon M Bennett

24. FUNERAL DIRECTOR ADDRESS: E. S. Boal, Westernport, Maryland

30809

VS. A15

RECEIVED
JUL 5 1950
BUREAU V. S.

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06842

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) 517 Greene St.

3. NAME OF DECEASED (Type or Print) (First) Francis (Middle) S. (Last) Newnam

4. DATE OF DEATH (Month) July (Day) 16 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Nov 3 1909
9. AGE last birthday 40 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jet Driller
10b. KIND OF BUSINESS OR INDUSTRY Rayon Mfg.
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel J Newnam
14. MOTHER'S MAIDEN NAME Margaret Loibel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 214-07-1683
17. INFORMANT AND ADDRESS Mrs Margaret L. Newnam, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio vascular

442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Renal disease (Uremia)

131a (c)

INTERVAL BETWEEN ONSET AND DEATH from 7-4-50.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.20, 1949, to 7-16, 1950, that I last saw the deceased alive on 7-15, 1950, and that death occurred at 2.50 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W.F. Williams, M.D. ADDRESS Cumberland DATE SIGNED 7-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 17 50
NAME OF CEMETERY OR CREMATORY Sts Peter & Pauls Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. July 17, 1950
REGISTRAR'S SIGNATURE Walter L. Wantz M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS " "

49605

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
JUL 25 1990
BUREAU T. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. 415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06843

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 35 Blackiston Ave

3. NAME OF DECEASED (Type or Print) (First) Mrs Catherine (Middle) (Last) O'Toole
4. DATE OF DEATH (Month) July (Day) 9 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M
8. DATE OF BIRTH March 30, 1906
9. AGE last birthday 44 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Meyersdale, Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thos J. Keegan
14. MOTHER'S MAIDEN NAME Sara C. McCleary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Charles J. O'Toole

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH 2 days

214X Antecedent cause(s)

56b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hysterectomy —

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mitral systolic murmur

19a. DATE OF OPERATION 6/24/50
19b. MAJOR FINDINGS OF OPERATION Fibrosis of uterus — post of adhesion
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23, 1950, to 7/9, 1950, that I last saw the deceased alive on 7/9, 1950, and that death occurred at A m., from the causes and on the date stated above.

SIGNATURE John K Rosgrove M D (Degree or title) ADDRESS Cumberland Md DATE SIGNED 7/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE July 12, 1950
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) Cumberland Md (State)

DATE REC'D BY LOCAL REG. July 10, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR James Scarpelli - Cumberland Md ADDRESS

Dr. Rogers
Mrs. O'Toole

RECEIVED
JUL 18 1950
BUREAU V. S.

Within corporate limits

06844

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 32 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 206 Wills Creek Ave.	STREET ADDRESS (If rural, give location) 206 Wills Creek Ave.

3. NAME OF DECEASED (Type or Print)	(First) DELPHIA	(Middle) LEAH	(Last) PARKER	4. DATE OF DEATH	(Month) July (Day) 18, (Year) 1950 19
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept.12,1896	9. AGE last birthday 53 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Laurel Dale, W. Va.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel Michael	14. MOTHER'S MAIDEN NAME Mary E. Westfall				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Geo. E. Parker, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) cancer of the breast (left) — 3 years

170 X Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 4-3-49	19b. MAJOR FINDINGS OF OPERATION far advanced cancer with malaise in axilla	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 1 , 1949, to 7-18, 1950, that I last saw the deceased alive on 7-10, 1950, and that death occurred at 2:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] MD — ADDRESS 57 Emerson St. — DATE SIGNED 7-18-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 7/20/1950	NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. July 19, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz M.D.	24. FUNERAL DIRECTOR Wm. H. Kight	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
JUL 25 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06845

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing, Md.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Wilhelmina (Last) Phillips

4. DATE OF DEATH: (Month) 7 (Day) 29 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 1853 - Feb. 4

9. AGE last birthday: 97 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christopher Schriver

14. MOTHER'S MAIDEN NAME: Leusetta --------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Allegany County Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	24 hrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	10 yrs
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

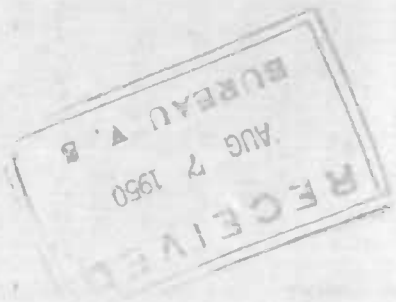
22. I hereby certify that I attended the deceased from Feb, 1947, to July 29, 1950, that I last saw the deceased alive on July 28, 1950, and that death occurred at 6:40 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M. D.	110 S. Centre St.	July 31, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 1, 1950	Laurel Hill Cem	Mascoy, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 31, 1950	Winter L. Kantz, M.D.	M. Eichhorn, Lonaconing, Md	

VS. A13


RECEIVED
AUG 7 1950
BUREAU V. S

Within corporate limits Dr. Durrett

06846

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland ~~West Virginia~~ COUNTY Allegany ~~General~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Branch (Rural)
STREET ADDRESS (If rural, give location) Rt#4 Cumberland, Md

3. NAME OF DECEASED (Type or Print) (First) NANCY ~~ANNA~~ (Middle) ANN ~~N.~~ (Last) PHILLIPS

4. DATE OF DEATH (Month) July (Day) 12 (Year) 50

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW
8. DATE OF BIRTH FEB. 3, 1877
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) West Virginia, Cass
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN CASSELL
14. MOTHER'S MAIDEN NAME Louise Cassell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL a Mrs Wm Darr, Rawlings, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	6 wks
260X Antecedent cause(s)	(b) Chronic nephritis	6 mos
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Diabetes mellitus	10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to July 12, 1950, that I last saw the deceased alive on July 12, 1950, and that death occurred at 11:10 A.M. from the causes and on the date stated above.

SIGNATURE Clark Durrett (Degree or title) MD ADDRESS Cumberland DATE SIGNED 7/13/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE July 14, 1950
NAME OF CEMETERY OR CREMATORY Zion Memorial Park
LOCATION (City, town, or county) Cumberland, Md (State)

DATE REC'D BY LOCAL REG. July 14, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 18 1950
BUREAU V. S.

Within corporate limits

06847

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md. (Rural)
STREET ADDRESS (If rural, give location) Rt 2

3. NAME OF DECEASED (Type or Print) (First) PEGGY Ann (Middle) Infant (Last) Porter
4. DATE OF DEATH (Month) (Day) (Year) July 22 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) White
8. DATE OF BIRTH July 22-50
9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John J. Porter
14. MOTHER'S MAIDEN NAME Mary L. Spielman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT AND ADDRESS Allegany Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) premature fetus

776X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

159 (c)

INTERVAL BETWEEN ONSET AND DEATH: 5½ months of gestation

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-22-, 1950, to 7-22, 1950, that I last saw the deceased alive on 7-22, 1950, and that death occurred at 4 15A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wilmos MD
ADDRESS 57 Greene St.
DATE SIGNED 7-22-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/22/50
NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery
LOCATION (City, town, or county) Morgan Co. (State) W.Va.

DATE REC'D BY LOCAL REG. July 22, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc.
ADDRESS Cumberland Md.

2-0-7-22-0-20 2-27-V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1960
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06848

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md. — LENGTH OF STAY (In this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 102 Paca St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural give location) 102 Paca St.

3. NAME OF DECEASED (Type or Print): (First) Glenna Irene (Middle) (Last) Portmess

4. DATE OF DEATH: (Month) July (Day) 17 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: July 22 1889

9. AGE last birthday: 60 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Private Home

11. BIRTHPLACE (State or foreign country): Springfield, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Wesley

14. MOTHER'S MAIDEN NAME: Addie V. Wiser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ralph K. Portmess Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Ventricular fibrillation	2-3 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mitral stenosis	15-20 yrs.
	(c) Aortic stenosis	" "

410X
92b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Benedict Skotarski M.D. Rt #2 Cumberland Md. 7/17/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 7/21/50 — NAME OF CEMETERY OR CREMATORY: Bethel Cem. — LOCATION (City, town or county) (State): Near Paw Paw W.VA.

DATE REC'D BY LOCAL REG.: July 19, 1950 — REGISTRAR'S SIGNATURE: Walter L. Dantz M.D.

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli Cumberland, Md.

RECEIVED
JUL 25 1901
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

06849

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 80 Greene Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louise		Pressman	7	3	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Single	7-25-74	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Pressman	Martha Schneider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	William C. Coble, 80 Greene St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Vascular Accident — Interval between onset and death: 5½ hrs

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Apr 15, 1950, to July 3, 1950, that I last saw the deceased alive on July 1, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	July 3, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7/6/50	Frostburg Memorial Park	Frostburg	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 6, 1950	Winter R. Beanty, M.D.	John J. Hofer	Cumberland, Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06850

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (In this place) MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) London (Last) Racey

4. DATE OF DEATH: (Month) July (Day) 29 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 14, 1914

9. AGE last birthday: 36 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Racey

14. MOTHER'S MAIDEN NAME: Dora Pregitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW #2

16. SOCIAL SECURITY NO.: 220-10-4598

17. INFORMANT: Mrs Charles L. Racey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset and Death

Immediate cause (a) Gunshot wound of chest — 976x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — 164C

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): Westernport, Allegany, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): July 29 m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Shot self at home

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benedict Skotarek M.D. Route #2 Cumberland, Md July 30 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: August 1, 1950

NAME OF CEMETERY OR CREMATORY: Queens Point Cemetery

LOCATION (City, town, or county) (State): Keyser, W. Va.

DATE REC'D BY LOCAL REG.: July 30/50

REGISTRAR'S SIGNATURE: G. Bazinbaker M.D.

24. FUNERAL DIRECTOR: E.B. Boal ADDRESS: Western Port. Md.

34049

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

16851

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
EVELYN	C.	REAGAN	July 19, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Single	Dec. 30, 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ass't Housekeeper	Rectory	Mt. Savage, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jermiah Reagan	Catherine Oakes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mrs. Carl Cessna, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	3 week, -
331X 83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Vascular Hypertension	5 years
	(c) Moderate Arteriosclerosis -	5 years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-1, 1950, to 7-19, 1950, that I last saw the deceased alive on 7-18, 1950, and that death occurred at 5:3. P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William E. Mosley		Mt Savage Md.	July 20-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/22/1950	St. Patricks Cemetery	Mt. Savage, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 22/1950	Wm. Harvey H. Poe	William H. Kight, Cumberland, Md.	

52086

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Within corporate limits

49

06852

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 134 South St

3. NAME OF DECEASED (Type or Print) Harold B. (First) (Middle) Baby Rice (Last)

4. DATE OF DEATH (Month) (Day) (Year) July 27 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) infant
8. DATE OF BIRTH July 27 1950
9. AGE last birthday - yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours 8 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Harold Bell Rice
14. MOTHER'S MAIDEN NAME Agnes Regina Hauser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Harold B. Rice 134 South St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776x Immediate cause (a) Prematurity 26 wks — INTERVAL BETWEEN ONSET AND DEATH 8 hrs

159 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 July, 1950, to ....., 19....., that I last saw the deceased alive on 27 July, 1950, and that death occurred at 6:35 P. m., from the causes and on the date stated above.

SIGNATURE Leland D. Ranson MD (Degree or title) ADDRESS 63 Greene St, Cumberland DATE SIGNED 28 July 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 7/28/50
NAME OF CEMETERY OR CREMATORY St Marys Cem.
LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. July 28, 1950
REGISTRAR'S SIGNATURE Winter L. Kantz, M.D.
24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland Md.

2-0-7-28-0-25-1-26-0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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Within corporate limits

06853

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany · MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. Maryland St. · COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland · LENGTH OF STAY (in this place): 50 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 106 E Third St.	STREET ADDRESS (If rural, give location): 106 E. Third St.

3. NAME OF DECEASED (Type or Print)	(First) Earl	(Middle) E.	(Last) Robertson	4. DATE OF DEATH	(Month) July 22, (Day) 1950 (Year) 19
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 9/2/1887	9. AGE last birthday: 62 yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Car Repairman	10b. KIND OF BUSINESS OR INDUSTRY: Railroad	11. BIRTHPLACE (State or foreign country): Flintstone, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: James R. Robertson	14. MOTHER'S MAIDEN NAME: Viola Wilson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): 1917-1919	16. SOCIAL SECURITY No.: 705-10-3808	17. INFORMANT AND ADDRESS: Mrs. Kathryn Robertson Cumberland			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
353.3	Immediate cause	(a) Cerebral Haemorrhage	20 hrs.
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epilepsy	20 hrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1950, to July 22, 1950, that I last saw the deceased alive on July 22, 1950, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clay R. Jurrett	M. D.	Cumberland	7/24/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/25/1950	Hillcrest Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
July 24, 1950	Winter R. Frantz M.D.	James F. Scarpelli Cumberland, Md.

98847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06854

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 210 Massachussetts Ave.

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Josephine (Last) Robey
4. DATE OF DEATH: (Month) July (Day) 16, (Year) 1950

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single
8. DATE OF BIRTH: July 9, 1950
9. AGE last birthday: yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry P. Robey
14. MOTHER'S MAIDEN NAME: Josephine F. Grabenstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Harry P. Robey 210 Massachussetts Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Patent Ductus Arteriosus — Interval Between Onset and Death: 7 days

754.1 Antecedent cause(s)

157.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Broncho Pneumonia — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 9, 1950, to July 16, 1950, that I last saw the deceased alive on July 16, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

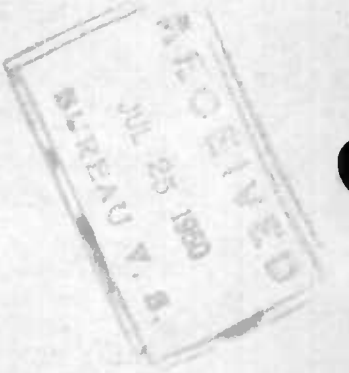
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Clay R. Jarrett M.D. Cumberland 7/17/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 7/17/50
NAME OF CEMETERY OR CREMATORY: St Mary's Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: July 17, 1950
REGISTRAR'S SIGNATURE: Walter K. Gantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland

240-7-090-28-3-40-4

VS. A15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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06855

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 78 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 17 Park St.

3. NAME OF DECEASED (Type or Print): (First) Hattie (Middle) Odella (Last) Rotruck

4. DATE OF DEATH: (Month) July (Day) 7 (Year) 1950

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed — 8. DATE OF BIRTH: May 18 1879 — 9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress — 10b. KIND OF BUSINESS OR INDUSTRY: At Home — 11. BIRTHPLACE (State or foreign country): Dudley W. Va — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eli Powers — 14. MOTHER'S MAIDEN NAME: Anna Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes. — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT AND ADDRESS: Walter C. Rotruck, City,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Embolism	10 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive heart disease	4 years
	(c)	

443X
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-27, 1950, to 7-7, 1950, that I last saw the deceased alive on 7-7, 1950, and that death occurred at 11 40P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ralph L. Ballin	M.D.	62 Greene St. Cumberland, Md	7-8-50

23. BURIAL, CREMATION or REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 11 50	Fairview Cem	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 10, 1950	Dexter R. Hawk, M.D.	Louis Stein Sons	" "

RECEIVED
JUL 18 1950
BUREAU V. S.

Within corporate DR. FAW

06856

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 40 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location) 701 LAFAYETTE AVE.

3. NAME OF DECEASED (Type or Print)	(First) ORENA	(Middle) Teresa	(Last) RUMMER	4. DATE OF DEATH	(Month) 7	(Day) 28	(Year) 50
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH AUG. 22 1878	9. AGE last birthday 71 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Penna.	12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME NERI RUBY	14. MOTHER'S MAIDEN NAME LOTTIE FULLER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intestinal obstruction with toxemia	4 days
5705 Antecedent cause(s)	(b) Intestinal adhesions post operative	2 years.
1222 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION July 28 1950	19b. MAJOR FINDINGS OF OPERATION Adhesions with complete obstruction	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1950, to July 28, 1950, that I last saw the deceased alive on July 28, 1950, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wyhe M Faw Jr	M.D.	Cumberland	Maryland.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	July 31 50	Hillcrest Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 31, 1950	Winter K. Frantz M.D.	Louis Stern Inc	Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
AUG 7 1950

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06857

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct place is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland — LENGTH OF STAY (In this place): 32 Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route #3, Bowman's Addn	STREET ADDRESS (If rural, give location): Route # 3. Bowman's Addn.

3. NAME OF DECEASED (Type or Print)	(First) Ida	(Middle) Marie	(Last) Shipley	4. DATE OF DEATH	(Month) July	(Day) 3	(Y..) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: May 11 1901	9. AGE last birthday: 49 yrs.	If under 1 year: Months.	Days	If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping	11. BIRTHPLACE (State or foreign country): Artemas Penna	12. CITIZEN OF WHAT COUNTRY?: US
13. FATHER'S NAME: Thomas Leasure		14. MOTHER'S MAIDEN NAME: Anna Belle Barnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: James M. Shipley Route 3 Cumberland	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma Uterus metastasis — 1-2 yrs

174X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b)

480 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 19 49, to July 3, 19 50, that I last saw the deceased alive on July 3, 19 50, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B. M. Schmidt M.D.		41 Grant St Cumberland Md	July 4 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 6 1950	Fairview Cemetery	Inglesmith, Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
July 5, 1950	Walter K. Frantz, M.D.	William H. Kight, Cumberland, Md.

52086

RECEIVED
JUL 11 1950
BUREAU V. S.

Within corporate limits DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06858

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY ALLEGANY MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND LENGTH OF STAY (in this place) 14 DAYS HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL CUMBERLAND, MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING, MARYLAND STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	DRUSILLA	May	SHOCKEY		JULY	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOWED	OCT. 30 1882	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES DYE	MARGARET FOUTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cancer (Hypernephroma) - Rt kidney	? months
180X Antecedent cause(s)	(b) Arteriosclerotic Ht Disease	? yrs.
52a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cardiac decompensation	4-6 wks.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 6/21, 1950, to 7/5, 1950; that I last saw the deceased alive on 7/5, 1950, and that death occurred at 1205 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. J. Mirkin	M.D.	115 So. Centre	7/6/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 8 1950	Oak Hill Cemetery	Lonaconing, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 6, 1950	Wenter K. Frantz, M.D.	M. Eschbach	Lonaconing, Maryland

VS. A15

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JUL 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06859

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place) 3 yr; MARYLAND

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) Jackson Street

3. NAME OF DECEASED (Type or Print): (First) Winnie (Middle) Charlotte (Last) Spiker

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Mar 9, 1885

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Maneul

14. MOTHER'S MAIDEN NAME: Nancy E. Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: William Henry Spiker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia (cons)	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic	1 Year
	(c) Chronic Nephritis	1 Year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 1 Year

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2, 1950, to July 2, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 6:30 P. m., from the causes and on the date stated above.

SIGNATURE: Paul A. Wilson (Degree or title) M.D. ADDRESS: Piedmont W. Va. DATE SIGNED: July 3, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: July 5, 1950

NAME OF CEMETERY OR CREMATORY: Laural Hill Cemetery

LOCATION (City, town, or county) (State): Moscow Maryland

DATE REC'D BY LOCAL REG. 7/5/50

REGISTRAR'S SIGNATURE: Jannette M Boal

24. FUNERAL DIRECTOR: M. Eichhorn ADDRESS: Lonaconing, Md.

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JUL 25 1950
BUREAU U. S.

06860

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) (Last) TANSEY				4. DATE OF DEATH (Month) July (Day) 21 (Year) 1950	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: Aug. 1, 1867	9. AGE last birthday: 82 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework	10b. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (State or foreign country): Ireland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Thomas Tansey		14. MOTHER'S MAIDEN NAME: Mary Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT AND ADDRESS: Miss Nellie Tansey, Mt. Savage, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause	(a) Hemorrhage of Stomach Intestine	3 hours
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Hemorrhage	12 days
	(c) Hypertension Heart disease	2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1940, to July 21, 1950, that I last saw the deceased alive on July 16, 1950, and that death occurred at 1.40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F. Alan G. Murray Mt. Cumberland Md July 27 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 7-24-50	NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REG.: July 22 1950	REGISTRAR'S SIGNATURE: Veronica McDermott	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 24 1950
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06861

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Rebecca (Middle) J. (Last) Taylor

4. DATE OF DEATH: (Month) 7 (Day) 1 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 9-1-62

9. AGE last birthday: 87 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Wesley Greene

14. MOTHER'S MAIDEN NAME: Emiline Greene

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Alleg. Co. Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	5 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	5 yrs
	(c)	

420.1 T4a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Oct 1, 1949, to July 1, 1950, that I last saw the deceased alive on July 1, 1950, and that death occurred at 8:50 p m, from the causes and on the date stated above.

SIGNATURE: Arthur F. Bowers (Degree or title) M.D. ADDRESS: 110 S. Centre St. DATE SIGNED: July 3, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE**: July 3, 1950 — **NAME OF CEMETERY OR CREMATORY**: Philos Cemetery — **LOCATION** (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: July 3, 1950 — **REGISTRAR'S SIGNATURE**: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR — **ADDRESS**: Boals - Westernport, Md.

RECEIVED
JUL 11 1950
BUREAU V. B.

Within corporate limits

06862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3II Lang Ave.	STREET ADDRESS (If rural, give location) 3II Lang Ave.

3. NAME OF DECEASED (Type or Print) (First) Margarett (Middle) M. Thorpe (Last)				4. DATE OF DEATH (Month) July (Day) 25, (Year) 1950 19	
5. SEX Femal	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 7/8/1875	9. AGE last birthday 75 yrs.	If under 1 year Months. Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg, W.Va.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin J. Custer			14. MOTHER'S MAIDEN NAME Mary Forny		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs Lolya Comer 3II Lang Ave.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	11 years
422.2 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	3 mon.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1950, to July 25, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 5:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clay 25, Surrey M. D. — Cumberland — 7/26/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 7/28/50	NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. July 26, 1950	REGISTRAR'S SIGNATURE Walter L. Frantz M.D.	24. FUNERAL DIRECTOR James F. Scarpelli	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

06863

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) 542 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
August	Samuel	Tribut	7	22	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Widowed	2-16-70	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired B&O Car Inspector	Railway	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry A. Tribut	Christine Longlotz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No —	None	Mrs Margaret E Boyd Cumbd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral vascular accident — Interval between onset and death: 1 mo

331X **Antecedent cause(s)**

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ / Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 13, 1950, to July 22, 1950, that I last saw the deceased alive on July 20, 1950, and that death occurred at 12:20 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	July 22, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	July 25, 50	St Patricks Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 24, 1950	Walter R. Dantz, M.D.	Louis Stein Inc	"

31847

RECEIVED
AUG 2 1950
BUREAU P. S

Within corporate limits

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06864

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. LENGTH OF STAY (in this place): 9 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 1101 VIRGINIA AVE.,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location): CUMBERLAND, MD.

3. NAME OF DECEASED (Type or Print)	(First) BERTHA	(Middle)	(Last) TROXELL	4. DATE OF DEATH	(Month) JULY	(Day) 20	(Year) 1950
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED	8. DATE OF BIRTH: 8/8/1889	9. AGE last birthday: 60 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME: BENNO KNOLL	14. MOTHER'S MAIDEN NAME: MARIE MEYERS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intestinal obstruction - pelvic abscess and surgical shock.	14 days
570.5 Antecedent cause(s)	(b) Partial intestinal obstruction	4 months
139a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) with multiple fecal fistula of abdominal wall.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 19 1950	19b. MAJOR FINDINGS OF OPERATION: Pelvic abscess - necrosis terminal ileum & sigmoid colon	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 11, 1950, to July 20, 1950, that I last saw the deceased alive on July 20, 1950, and that death occurred at 9:20 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wylie W. Faw Jr.	M.D.	Cumberland	Maryland

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 7/22/50	NAME OF CEMETERY OR CREMATORY: Greenmount Cem.	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: July 22, 1950	REGISTRAR'S SIGNATURE: Winter R. Krantz, M.D.	24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1950
BUREAU V. S.

Within corporate limits

DR. HALLINAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Called Hafer 7/17/50

06865

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 31 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 304 COLUMBIA STREET,

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) Marshall (Last) WEAVER

4. DATE OF DEATH: (Month) JULY (Day) 16 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: APRIL 3, 1941

9. AGE last birthday: 9 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: EARL WEAVER

14. MOTHER'S MAIDEN NAME: VIRGINIA PORTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Portal obstruction - Complete

156.1 Antecedent cause(s)

46f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of the Liver

(c) ascites - massive

INTERVAL BETWEEN ONSET AND DEATH: 41 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 16, 1950, to July 16, 1950, that I last saw the deceased alive on 7-16-50, 1950, and that death occurred at 9:16 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James P. Nacemon MD 200 Decatur St. Cumberland Md 7/17/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE July 19, 1950; NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park; LOCATION (City, town, or county) Cumberland; (State) Md

DATE REC'D BY LOCAL REG. July 19, 1950; REGISTRAR'S SIGNATURE Walter L. Mantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Md.

VS-A15

RECEIVED
JUL 25 1901
BUREAU T. S.

Within corporate limits

Welsh.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06866

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 25 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 315 E. Offutt St.

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Nevada (Last) Welsh

4. DATE OF DEATH: (Month) July (Day) 30 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 11, 1909

9. AGE last birthday: 40 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Spun Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Sand Patch, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Martz

14. MOTHER'S MAIDEN NAME: Emma Horsroad

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Raymond Welsh, 315 E. Offutt St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Embolism, massive	1/2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Thrombosis, right leg.	12 hrs.
	(c)	

466X
50
170X

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of left breast — 1 year

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benedict Skotarelis, M.D. Rt #2 Cumberland, Md. 7/30/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Aug. 2, 1950 | NAME OF CEMETERY OR CREMATORY: Vale Summit Methodist Cemetery | LOCATION (City, town, or county): Vale Summit, (State): Md

DATE REC'D BY LOCAL REG.: Aug. 2, 1950 | REGISTRAR'S SIGNATURE: Monte R. Hartz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Md.

49616

RECEIVED
AUG 7 1950
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

06867

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits write RURAL and OR give nearest town) TOWN Frostburg
LENGTH OF STAY (in this place) 14 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Vocation
STREET ADDRESS (If rural, give location) R.D. No1 Frostburg, Md.

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Walter (Last) Wilkes

4. DATE OF DEATH: (Month) July (Day) 6 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-2-1895

9. AGE last birthday: 55 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Barton Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benamin Wilkes

14. MOTHER'S MAIDEN NAME: Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-09-6565

17. INFORMANT AND ADDRESS: Mrs Harry W Wilkes R.D. No 1 Frostburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163x **Immediate cause** (a) cancer of lung — Interval between onset and death: 4 months

47d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1950, to July 5, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 9:15 p.m., from the causes and on the date stated above.

SIGNATURE: Adolf Wolfrum (Degree or title) M.D. ADDRESS: Frostburg Md. DATE SIGNED: 7-6-50

23. BURIAL, CREMATION / REMOVAL (Specify): Burial — DATE THEREOF: 7-8-1950 — NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery — LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REG. 7-8-50 — REGISTRAR'S SIGNATURE: Mrs. J. M. Price acting — 24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.

45402

VS. A15

RECEIVED
JUL 10 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06868

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 413 Maryland Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Othillia	Massey	Wilson	July	7	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Single	May 31 1878	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House	House Keeping	Rush, Maryland	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel F. Wilson	Mariah Susan Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	George W. Martin, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Myocarditis	3 mo
2192x Antecedent cause(s)		
93a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Atypical Pneumonia	3 mo
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
~				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4-24, 1950, to 7-7-50, 19....., that I last saw the deceased alive on 7-7-50, 19....., and that death occurred at 9.50 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
C. Zimmerman MD	Cumberland Md	7-7-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	July 9 1950	Rose Hill Mausoleum	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 9, 1950	Winter K. Frantz, M.D.	William H. Kight,	Cumberland, Md.

52086

VS. A15

RECEIVED
JUL 19 1950